ST. LUCIE COUNTY SPECIAL NEEDS REGISTRATION

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ Zip Code: _____

Home Phone # _____ Cell Phone #: _____ Sex ___ DOB: _____

Doctors Name: _____ Phone # _____ Office Address_____

Do you need TDD Notification? Y / N Winter Resident Only Y / N Religious Preference_____

Next of Kin: _____ Phone # _____ Is phone # same as registrant? Y/N

CARE GIVER ACCOMPANYING YOU TO SHELTER

Care Giver Name: _____ Care Giver Phone # _____

Address: _____ Care Giver Relationship: _____

Notes /Comments: _____

_____

HEALTH INFORMATION

Disability Notes: _____

_____

_____

Medications: _____

_____

Allergies to Medications/Other: _____

_____

Pace Maker Y / N Model: _____ Oxygen? Y / N **Medically** depend on electricity? Y / N

Hospice Patient: Y / N Hospice Name _____

TRANSPORTATION

(PLEASE CHECK APPROPRIATE NEEDS)

____ I need transportation only, I have no way to get to a shelter.

____ I need transportation and medical attention.

____ I need medical attention only, I have transportation.

Do you use a wheelchair? Y / N   Are you wheelchair bound? Y / N Are you bedridden? Y / N Wheelchair ramp available? Y / N

Home Type: ___ Mobile Home ___ Manufactured Home ____Condominium ___Apartment

Name of Mobile Home/Manufactured Home Park or Apartment ___________________________

Please note: Medical shelters may not be air conditioned if emergency power is required.

PLEASE CONTINUE ON PAGE THREE OF THIS FORM

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(FOR OFFICIAL USE ONLY)

South Shelter __ North Shelter __ Transportation Type ____ Medical Needs ____ Transp: ___

Zone: _____________   Plant Evacuation Area: ____   Assigned Shelter Section ___ Bed# _____

Check In Date/Time: __________________ Check Out Date/Time: _________________

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*******MEDICAL NEEDS CRITERIA********

From criteria listed below, indicate with a check mark, one or more, that describes your medical need(s).

___ Persons dependent upon a **health professional to administer injectable medications.**

___ Persons requiring daily or more frequent dressing changes **by a health care professional.**

___ Persons needing assistance **by a health care professional** with ostomy management, continuous peritoneal dialysis or indwelling catheters of any kind.

___ Persons whose activities of daily living are so **restricted by immobility** that their basic medical needs must be met by others.

___ Persons who require daily assessment of **unstable medical condition by Professional nursing personnel,** i.e., diabetes, cardiac, cystic fibrosis.

___ Terminally ill patients who are in need of professional **assistance for administering** heavy doses of medication.

___ Any resident whose **life depends upon electrically energized equipment** within his/her residence (i.e. suction machines, home dialysis machines, o2 concentrators) excluding electric wheelchair without other qualifying condition.

___ Those who **depend** on oxygen therapy.

___ Bedridden and require custodial care upon **advice of a personal physician.** (As per Florida Statutes – does not necessarily mean assigned to special needs medical facility. Other facilities such as a nursing home or hospital will be utilized.

IMPORTANT

If you have checked any of the medical needs criteria, please complete the following questions.

1. Do you currently have a home health nurse coming to your home: Yes / No.

2. If yes, name of agency that provides your special care_____

3. If no, who provides your special care now?_____

4. Specifically what type of care are you now receiving? Please be very specific.
_____
_____
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PLEASE NOTE: MEDICAL SHELTERS MAY NOT BE AIR CONDITIONED IF EMERGENCY POWER IS REQUIRED.

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Patient's Signature:_____ Date:_____

Person completing form_____ Date:_____
(If other than patient)

Send Completed Form To:
St. Lucie County Public Safety
101 North Rock Road
Fort Pierce, Fl 34945
(772) 461-5201

Essential Items You Must Bring To The Medical Shelter

1. **Pillow, blanket and linens.**

2. **Three day supply of non-perishable food for individual taste and/or special diet.**

3. **Three day supply of drinking water in non-breakable container(s). (1 gallon per day, per person)**

4. **Prescription medications in their prescription bottles.**

5. **Medical supplies.**

6. **Vital medical equipment i.e. oxygen concentrators, portable oxygen bottles.**

7. **Personal Items:**

    a. **Important papers (Personal identification. Insurance policies).**
    b. **Reading Glasses.**
    c. **Personal hygiene articles (tooth brush, soap, towel, wash cloth)**
    d. **Change of clothing.**
    e. **Sweater or jacket.**
    f. **Rainwear.**
    g. **Flashlight with extra batteries.**
    h. **Quiet games i.e. cards, book, knitting.**